



Position statement: GP-led aged care in rural Australia

Endorsed: July 2016



Strategic objective

Addressing the difficulties faced by older patients as they access healthcare relies on strong system capacity to enable continuity of care. The complex needs and broad range of services utilised by aged care patients requires careful planning to develop appropriate models of care in a changing workforce structure and ageing population.

Complexities may arise when patients move in and out of primary and tertiary care, with some transferring between hospitals and aged care facilities, while others require support returning to a home setting or just to stay at home for longer.

Ensuring continuity of care for rural patients is made more complex due to diminished services, as well as an already overstretched workforce. Enabling rural GP-led aged care offers a more viable service solution to address these challenges.

Position summary

Our research shows that there are significant barriers preventing GPs from undertaking aged care across each of the key settings: community based, residential aged care, and in hospitals.

Despite strong rural GP participation across all settings, the frequency of service results showed a clear underutilisation of the local GP workforce, with limited patient reach in each setting outside of the practice.

Member informed research

Over 490 rural general practitioner (GP) members responded to an RACGP Rural survey on aged care services in February 2016. Members provided feedback about the delivery of aged care in their rural communities, confirming that there are significant barriers preventing them from meeting patient need. This consultation forms the basis of this position statement.

What are the key challenges?

The key barriers to the provision of rural GP-led aged care outside of the practice setting include:

Service constraints

1. Time constraints and workload
2. Financial feasibility
3. Difficulty meeting after hours and home visit requirements
4. Poor service integration
5. Deficient allied health service mix

Workforce barriers

1. Inadequate remuneration
2. Lack of skill recognition
3. Local GP workforce shortages

Broader factors

1. Lack of geriatrician support
2. Bureaucracy and red tape
3. Inadequate level of qualified nursing staff in residential aged care facilities (RACFs)

Rural GP-led models of care

Rural GPs need targeted incentives to increase their capacity to work outside of the practice. Participation barriers which limit more frequent care across settings clearly show that priority must be given to policies designed to increase capacity beyond the practice.

Expanded targeted incentives are required to support rural GPs to provide this care, particularly at the community level (in-home visits) which help the patient stay at home longer. Rurally viable models of care are reliant on a commitment to continued funding at levels which can sustain these services to reduce reliance on in-reach services and hospitalisations.

One of Australia's biggest future health challenges lies in aged care. It is vital to plan now to target areas of critical need to meet the growing demand.

'Our research shows that the valuable work our rural GPs perform across the various aged care settings is limited by the time they can take away from in-practice work, and that they are not being remunerated for the bulk of this work. Reducing redundancies in the system and revising the fee structure for aged care work in different settings would reduce the workforce burden and hopefully stimulate more interest in this growing area of healthcare.'

Dr Ayman Shenouda, RACGP Rural Chair

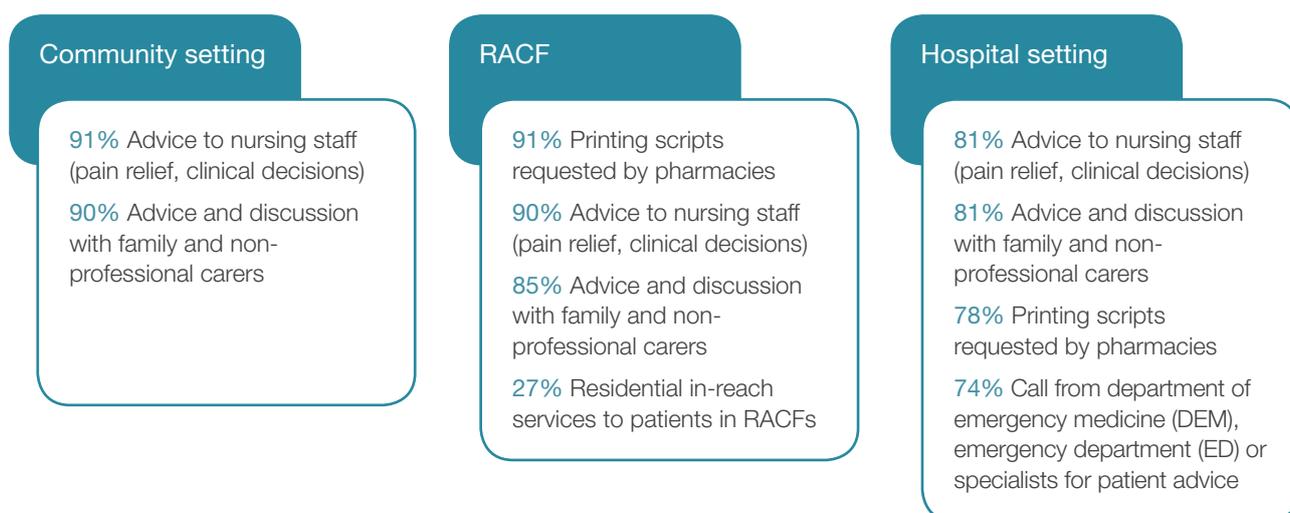
Policy solutions

Remuneration is key and this factored strongly in the 2016 RACGP Rural Aged Care Survey as a major barrier to participation outside of the practice. Examination of the fee structure by policy makers could turn one of the largest identified barriers to care into an enabler, by recognising and adequately compensating GPs for the complex care required in aged care across all settings.

Remuneration barriers for rural GPs across settings

The following figures indicate the percentage of rural GPs who considered the identified aged care service elements to be non-remunerated.

Source: Rural Aged Care Survey, February 2016



Policy solutions: Eight key measures

1. Workforce participation

More recognition around time commitment, currently non-remunerated or underfunded, for the provision of aged care work in these broader service contexts is important.

Addressing financial disincentives through extending Medicare Benefits Schedule (MBS) items to capture unpaid service elements, such as GPs doing a ward round, giving advice to nurses or undertaking family meetings, would improve service frequency across these settings and improve patient access and service capacity.

Utilising trainees, including medical students and interns, would provide early exposure, promote interest in the field of aged care and help to lift local workforce constraints.

2. Efficiency measures

Policy attention around efficiency measures to alleviate service burden would increase rural GP-led care and service capacity. Improved case management and coordination, for example, can be achieved through improved internet speeds in rural and remote RACFs and better access to computers with secure links to practice clinical information systems. The use of Secure Message Delivery (SMD) as the preferred method of electronic communication, rather than faxes that must be scanned into GPs' clinical information systems, would also provide for more efficient processes.

Attention should also be given to reducing the redundancy in non-remunerated system issues, such as the inability for many facilities to dispense from the facility medication charts, and the challenges of printing medication charts using the information already available within the GP Clinical Information System (CIS).

Streamlining discharge planning to ensure more efficient release processes and stronger recognition of the GP's role in continuity of care are also important factors. This could include a requirement for a discharge summary preparation prior to discharge and the funded involvement of the patient's regular GP in the discharge planning processes.

3. Lifting system constraints

To ensure continued independent living, a focus on enabling integrated support across the full multidisciplinary team, particularly in strengthening transition care arrangements, is required to lift system constraints. Improving the integration between services as patients transition during their healthcare journey would assist in reducing unplanned readmissions and pressure on EDs.

Increased funding for residential in-reach services, enabling provision of a mix of community and acute aged care services, would help reduce the reliance on EDs and acute wards, and more costly care.

4. Supportive infrastructure

Investment across a broad range of infrastructure and supports, including built infrastructure, bed capacity and/or interim facilities and equipment is needed to support rural aged care services. For example, built infrastructure in the form of a treatment room in RACFs would ensure a more cost-effective service solution by avoiding unnecessary transfer. Funding for more beds, short stay acute geriatric presentations and interim facilities for patients awaiting placement in nursing homes is also required.

More appropriate resources overall, including mobility aids and access to services which include occupational therapy, social work, paramedical services and broader specialist support through telehealth (including to geriatricians) would improve local service capacity.

5. Multidisciplinary team supports

There is a need to acknowledge a reliance on the full multidisciplinary team in providing quality aged care services. Addressing fragmentation system issues in allied health services where patient information flows are restricted would support stronger GP-led models of care.

Appropriately qualified nursing cover and adequate staffing levels is also a high priority among RACGP members, particularly in terms of capacity in RACFs. In the practice setting, the nurse practitioner model is seen as an essential supportive structure in facilitating community-level care with the need for increasing funding levels.

6. Advanced psycho-geriatric skillsets

Rural GP skills in demand do not differ significantly between settings. The skills featuring through survey across settings include chronic disease management, chronic pain management, palliative care and acute care. Dementia and mental health issues factor more in RACF and hospital settings. Dementia care and depression, including mood disorders, are key in the RACF setting, while in-hospital delirium and dementia care are more relevant to the hospital setting. Future workforce planning should therefore prioritise psycho-geriatrics, dementia and behavioural and psychological symptoms of dementia (BPSD) skillsets to address increasing demand.

7. Access factors

A supportive strategy to ensure rural GPs have access to advice around the management of difficult psycho-geriatric patients in these settings could be achieved through the investment in an online resource, similar to Tele-Derm. An eHealth 'store and forward' national telehealth service would provide rural GPs access to specialist advice in a timely manner, as well as a platform for learning and discussion. Other broader constraints such as those relating to Aricept (donepezil), which can only be initiated by a specialist, should also be reviewed to ensure access for rural patients with Alzheimer's disease.

8. Accessible training

Supporting skill utilisation and enabling GP-led aged care services provides for a more viable services solution in rural communities. In meeting current and future skill need through a highly skilled rural GP workforce, it is clear that access to upskilling opportunities are key. Training must be accessible and undertaken in the local setting to reduce service impacts and time away from patients. This is consistent with broader research in advanced skills, undertaken by the RACGP in 2014, where access to training is reliant on a supportive framework which enables service continuity and practice viability in rural areas.

RACGP | Rural recommendations

1. Reward complexity through extending MBS items to capture unpaid and underpaid service elements.
2. Drive efficiencies through measures which alleviate service burden by improved case management and coordination, including:
 - improved internet speeds in RACFs
 - better access to secure links to practice clinical information systems
 - simplifying prescribing arrangements
 - streamlining discharge planning process.
3. Provide funding supports which enable continued independent living, including expanding residential in-reach services to help address capacity issues in acute care.
4. Fund supportive infrastructure, built and functional supports, to improve local service capacity.
5. Ensure the full multidisciplinary team is well supported and capable of delivering the level of care required in each setting, with a priority on skill capacity within RACFs.
6. Prioritise GP skill-acquisition in psycho-geriatrics, dementia and BPSD skillsets to address increasing demand.
7. Invest in eHealth solutions including a 'store and forward' national telehealth service to facilitate easy access for rural GPs to broader specialist advice.
8. Funding to support accessible training options for rural GPs to undertake training from within their rural community.

Reference

The Royal Australian College of General Practitioners. RACGP Rural Aged Care Survey. 2016. Available at www.racgp.org.au/yourracgp/facilities/rural/projects/aged-care-survey